

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-020293

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2681

FILED MAY 29 1963

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

E. A. Wilkinson MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Lafayette</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		c. CITY OR TOWN <b>Odessa</b>	
Length of stay in 1b <b>9 weeks</b>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) <b>Research Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>309 S. First</b>	
Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. NAME OF DECEASED (Type or print) <b>Richard Dean Schlickelman</b>		4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>1963</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/2/1946</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>	11. BIRTHPLACE (City and state or country) <b>Independence, Mo.</b>
13a. FATHER'S NAME <b>Arnold Schlickelman</b>		13b. MOTHER'S MAIDEN NAME <b>Reba Mae Hensley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		17. INFORMANT Address <b>Arnold Schlickelman, Odessa, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ossleous + Soft Tissue Lympho-Sarcoma,</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Metastatic.</b>		DUE TO (c) <b>Primary lympho-sarcoma left lung.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <b>May 1962</b> to <b>May 8, 1963</b> and last saw him alive on <b>May 7, 1963</b>		Death occurred at <b>2</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>E. A. Wilkinson, M.D.</b>		22b. ADDRESS <b>6400 Prospect.</b>	22c. DATE SIGNED <b>5/8/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5/11/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City, town, or county) <b>Independence, Jackson, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ralph O. Jones, Odessa, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-P-63</b>	26. REGISTRAR'S SIGNATURE <b>Puth Long</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
 or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
 working under my personal supervision.

Student \_\_\_\_\_  
 Signature of Student Embalmer

Signed

*Ralph Jones*

Licensed Embalmer No.

*4604*

P. O. Address

*Odesa, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
 If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
 If this body is not embalmed, fact should be so stated above.